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F 000	INITIAL COMMENTS The following citations represent the finding of a Health Resurvey and complaint Investigations KS00072686 and KS00072684.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview the facility failed to complete a significant change assessment for 1 (#34) of the sampled residents. Findings included: - The Annual Minimum Data Set 3.0 (MDS) dated 3/14/14 for resident #34 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. He/she displayed hallucinations (sensing things while	F 274		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The resident was independent with bed mobility, transfers, walking in his/her room, walking in the corridor, locomotion on the unit, and locomotion off the unit. He/she required staff supervision for dressing and toilet use, staff supervision and set up for personal hygiene and eating, and extensive assistance from 1 staff member for bathing. The resident was frequently incontinent of bladder and always continent of bowel.

The Quarterly MDS dated 6/6/14 revealed a BIMS score of 12, indicating moderate cognitive impairment. He/she displayed hallucinations and delusions. The resident was independent with bed mobility, transfer, walking in his/her room, walking in the corridor, locomotion on the unit, and locomotion off the unit. He/she required staff supervision for dressing, eating, and toilet use. He/she required staff supervision and set up assistance for personal hygiene, and required staff set up assistance for bathing. The resident was always continent of bladder and bowel.

Comparison of the 2 assessments revealed 2 or more changes in the resident's activities of daily living (ADLs) abilities and bladder continency status.

The 3/26/14 Care Area Assessment for ADLs revealed staff provided prompting to the resident for brushing his/her teeth, changing clothes, bathing, and washing his/her hands after voiding. Staff provided assistance with ADLs as needed related to the resident's weakness due to low blood sugars or complaints of weakness.

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Observation on 7/10/14 at 3:06 P.M. the resident sat on the couch in the day room watching television.

Interview on 7/15/14 at 7:58 A.M. with licensed nursing staff H revealed the MDS coordinator was responsible for completing the MDS assessments. Staff H expected him/her to complete the assessments correctly and he/she verbally notified the MDS coordinator of any observed changes as needed.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff E revealed he/she completed the MDSs for the residents. He/she reported if the resident had a change in 2 different areas lasting more than 2 weeks then he/she completed a significant change assessment. He/she stated, if the change was persistent over 2 weeks, not just the 7 day look back period, then he/she would complete a significant change assessment.

Interview on 7/15/14 at 11:29 A.M. with administrative nursing staff D revealed he/she expected staff to complete a significant change assessment if a resident met the criteria.

The June 2012 policy provided by the facility regarding the resident assessment revealed a significant change assessment was completed by staff when it was determined that the resident had a significant decline or improvement in their physical, mental, or psychosocial condition, or when the resident's status changed to the extent that the current plan of care no longer reflected the resident's needs.

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F 274	Continued From page 3 The facility failed to complete a significant change assessment for this resident with moderate cognitive impairment, who showed improvements in bathing and eating abilities, and a change in bladder continency status.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan that was individualized to the residents's needs for 3 sampled resident #13 for individual	F 279		

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coping skills, #41 for nutrition and #35 for bathing.

Findings included:

- Resident #13's July 2014 physician's order sheet (POS) recorded the resident was admitted to the facility on 5/28/14 with a diagnosis of schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction).

The admission Minimum Data set 3.0 (MDS) assessment dated 6/6/14 recorded the resident could not complete a Brief Interview for Mental status which indicated the resident's cognition was severely impaired. The MDS recorded the resident exhibited threatening behaviors, screaming and yelling at others daily during the review period, required limited assistance with activities of daily living in effect, mobility, dressing, toilet use and personal hygiene, had daily pain at a level of 6 on 1 to 10 scale (10 being extreme). This same assessment documented the resident received anti-depressant (medication to alleviate feelings of sadness) and anti-anxiety (medication to decrease a resident's stress level) medications. The 6/10/14 admission Care Area Assessment (CAA) for behavior and psychosocial adjustment recorded the resident's behavior severely interrupted his/her ability to interact with others and dramatically upset the living environment and peers with screaming, cursing, and threatening others.

The resident's care plan dated 7/10/14 documented the residents would be compliant with his/her medications 100 percent of the time

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thru the next 90 days and would identify one new coping skill by 7/9/14. The care plan directed staff to attempt to educate the resident about his/her medications and teach skills to help with anger management and mood regulation.

The care plan lacked documentation of any specific methods used to educate the resident regarding his/her medications and/or individualized coping strategies to deal with the resident's disruptive behaviors.

Observation at various times on 7/9/14 and 7/10/14 at various times between 7:40 A.M. and 4:00 P.M. the resident had an unkempt appearance, ambulating in the halls and to and from the dining room, yelling, cursing, and scolding in an aggressive manner toward staff and other residents.

On 7/10/14 at 8:30 A.M. administrative licensed nursing staff D stated care plans were developed by the team, MDS coordinator, activity director, social services, and dietary, and reviewed weekly. An interim care plan was done when the resident was first admitted to the facility and; there was a 14 day period when staff assessed the resident and then staff met and developed a comprehensive care plan within 30 days of admission. Administrative licensed nurse D stated the nursing staff updated the resident's care plans as applicable to the resident's care needs.

The 2012 Care Planning & Care Conference policy documented the care plan would : "reflect interventions to meet both short and long term resident goals," and "consider the Care Area Assessments (CAA) and care area triggers which

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serve as a link between the MDS and Care Plan."

The facility failed to develop a comprehensive care plan with interventions designed to meet the resident's goals of compliance with medications and using individual coping skills for this cognitively impaired resident with a mental disorder.

- Resident #41's July 2014 physician's order sheet (POS) recorded the resident was admitted with a diagnoses of End Stage Renal Disease (a disease condition that was terminal because of irreversible damage to vital tissues or organs (kidney).

The annual Minimum Data set 3.0 (MDS) assessment dated 6/10/14 recorded the resident had a Brief Interview for Mental status score of 14 which indicated the resident's cognition was intact. The MDS recorded the resident required limited assistance with activities of daily living for mobility, dressing, toilet use and personal hygiene. The assessment further documented the resident received dialysis (a mechanical method of blood purification) three times a week.

The 6/23/14 Care Area Assessment (CAA) for cognition recorded the resident's renal disease could affect his/her cognition when he/she did not follow his/her diet recommendations.

The CAA for nutrition dated 6/23/14 recorded renal disease caused problems with calcium phosphorous and potassium (necessary electrolytes in the blood) in the blood as well as albumin (protein) levels.

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The resident should watch intake of foods containing these items but he/she did not follow his/her diet. The resident received protein snacks at bedtime but refused them as well as Phoslo (dietary supplement for residents with renal disease). He/she received encouragement and support from staff.

Review of the registered dietician note dated 7/8/14 listed at times the resident refused weight assessment, stated food preferences, became agitated if he/she did not get what he/she wanted, did not follow his/her diet, staff encouraged good intake of a regular diet, limited high potassium foods, and staff offered a protein supplement every evening.

The care plan dated 7/10/14 lacked documentation of the resident's nutritional status, the need to limit foods containing potassium, his/her non-compliance with his/her diet, his/her high protein snacks, and use of dietary supplements.

Observation on 7/10/14 at 12:00 P.M.. the resident was in the main dining room and ate approximately 70 percent of his/her lunch.

On 7/15/14 at 2:00 P.M. the resident stated he/she was not on any diet restrictions, could have whatever he/she wanted, and stated he/she received enough food at meals.

On 7/10/14 at 8:30 A.M. administrative licensed nursing staff E stated care plans were developed by the team, MDS coordinator, activity director, social services, dietary, and reviewed weekly. An interim care plan was done when the resident was first admitted and there was a 14 day period

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when staff assessed the resident and then staff met and developed a comprehensive care plan within 30 days of admission. Administrative licensed nurse D stated the nursing staff updated the residents' care plans as applicable to the resident's care needs.
The 2012 Care Planning & Care Conference policy documented the care plan would "consider the Care Area Assessments (CAA) and care area triggers which serve as a link between the MDS and Care Plan."
The facility failed to develop a comprehensive care plan that included nutritional information (diet, restrictions, use of supplements, etcetera) for this resident who required nutritional interventions.

- The Quarterly Minimum Data Set 3.0 (MDS) dated 5/16/14 for resident #35 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. The resident displayed symptoms of delirium (sudden severe confusion, disorientation and restlessness), had delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), and had hallucinations (sensing things while awake that appeared to be real, but the mind created). He/she also displayed verbal behavioral symptoms directed towards others 4 to 6 days of the look back period. The resident was independent with bed mobility, transfers, walking in his/her room, walking in the corridor, locomotion on the unit, locomotion off the unit, and toilet use. He/she required supervision from staff for eating, bathing, and personal hygiene. The resident required limited physical assistance from 1 staff member for dressing.

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The 3/5/14 Care Area Assessment (CAA) for Activities of Daily Living (ADLs) revealed staff supervised the resident during meals for safety and provided encouragement to perform his/her ADLs and bathe as needed. The resident had periods of not wanting to bathe or adequately caring for his/herself.

The ADL care plan with a revision date of 6/20/14 revealed staff provided the resident with cueing and set up related to bathing. The staff provided items needed for personal hygiene such as a hair brush.

The care plan lacked individualization regarding the resident's bathing preferences.

The monthly summary signed 6/23/14 revealed the resident was independent with his/her ADLs and "does most of {his/her} clean up in the sink." The resident was able to make his/her needs known.

Observation on 7/10/14 at 4:08 P.M. revealed the resident sat at a table in the dining room actively participating in a group craft activity.

Interview on 7/14/15 at 4:04 P.M. with direct care staff R revealed he/she was unsure of the resident's preferences regarding showering.

Interview on 7/14/14 at 4:22 P.M. with licensed nursing staff H revealed the resident preferred to clean him/herself up at bedside or in his/her bathroom. At times the resident used the beauty shop to wash his/her hair. Staff provided the resident with supplies such as washcloths, towels, and wipes. Staff H was unsure if he/she expected the care plan to show these

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preferences but did expect staff to individualize the care plan for the resident.

Interview on 7/15/14 at 7:58 A.M. with licensed nursing staff H revealed all nurses were able to update the care plan. Staff H reported he/she was unsure which staff member developed the comprehensive care plan.

Interview on 7/15/14 at 7:59 A.M. with direct care staff T revealed the resident usually cleaned him/herself up in his/her room. Staff T reported staff provided the resident with supplies for clean up in his/her room such as towels but the resident preferred to use his/her own shampoo. Staff T reported the resident notified staff if he/she wanted to use the actual shower room and the staff provided set up assistance.

Interview on 7/15/14 at 8:08 A.M. with the resident revealed he/she often preferred to wash up independently in his/her room. The resident reported he/she would notify the shower aid if he/she desired to use the shower room.

Interview on 7/15/14 at 8:19 A.M. with direct care staff S revealed the resident was independent with his/her cares and was able to verbalize his/her needs. Staff S stated he/she expected staff to individualize the care plan for each resident since they were all so different.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff E revealed the MDS coordinator developed the comprehensive care plan for new residents and updated the care plan with help from other staff. Staff E acknowledged this resident's care plan lacked individualization regarding bathing and expected the care plan to

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F 279	Continued From page 11 be more specific for him/her. Interview on 7/15/14 at 11:29 A.M. with administrative nursing staff D revealed he/she expected staff to individualize the care plan for each resident. The January 2012 policy provided by the facility regarding care planning revealed a comprehensive care plan must be developed for each resident and address the residents' individual needs, strengths, and preferences. The facility failed to develop a comprehensive, individualized care plan for this resident regarding bathing preferences.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview the facility failed to perform neurological checks for 1 resident (#3) who had a fall and hit his/her head. Findings included:	F 309		

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- The signed Physician's Order Sheet (POS) dated 6/12/14 for resident #3 revealed diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), and seizures (violent involuntary series of contractions of a group of muscles).

The annual Minimum Data Set 3.0 with an Assessment Reference Date of 6/20/14 revealed the resident had a Brief Interview for Mental Status of 15 and had delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue). He/she was independent with bed mobility, transfers, walking in the room and the corridor, locomotion on and off the unit, dressing, and toilet use, required supervision with personal hygiene and eating, was steady at all times when moving from a seated to a standing position, when walking, when turning around and facing the opposite direction while walking, and with surface to surface transfers, had no limitations in range of motion, was always continent of bowel and bladder, and had no falls since the prior assessment.

The Care Area Assessment (CAA) dated 6/27/14 revealed the resident was at increased risk for falls due to use of clozaril (a medication used to treat psychosis-any major mental disorder characterized by a gross impairment in reality testing) and clonazepam (a medication used to treat anxiety-mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and their potential side effects. He/she also had an increased risk due to the affects of schizophrenia on his/her cognition.

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The fall care plan initiated on 9/3/13 and revised 7/4/14 revealed the resident reported a fall to the nurse on duty and had an abrasion to the right cheek and left knee. Prior to the 7/4/14 fall, the 9/3/13 interventions were to ensure proper footwear, ensure the call light was within reach, and ensure good lighting. After the fall on 7/4/14, interventions were updated to re-educate the resident about using the call light, ensure the night light was on, ensure good footwear, check on the resident more frequently, and reassess frequently for pain.

An interview on 7/9/14 at 11:01 A.M. with licensed nursing staff H revealed the resident reported a fall on 7/4/14 stating he/she got tangled in the blankets at night when he/she got up to go to the bathroom. The fall was not witnessed and the resident received an abrasion to his/her left cheek.

Accident investigation information provided by the facility lacked evidence of neurological checks.

The clinical record lacked neurological checks (assessment of sensory neuron and motor responses, especially reflexes, to determine whether the nervous system is impaired).

On 7/10/14 at 2:56 P.M. the resident was observed ambulating in the hallway independently with a steady gait.

On 7/14/14 at 7:38 A.M. the resident sat in the dining room and ate breakfast.

Interview on 7/14/14 at 3:07 P.M. with direct care

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F 309	Continued From page 14 staff P revealed when a resident fell he/she assisted the nurse with vital signs and assessing for pain. Interview on 7/14/14 at 3:09 P.M. with licensed nursing staff H revealed if a resident fell and hit their head he/she did neurological checks per the facility's protocol. Licensed nursing staff H acknowledged he/she did not initiate neurological checks when this resident fell and hit his/her head on 7/4/14. Interview on 7/14/14 at 4:35 P.M. with administrative nursing staff D revealed anytime a resident fell and hit their head, nursing staff did neurological checks. The policy for fall management revised August 2012 provided by the facility did not address performing neurological checks for a resident who fell and hit his/her head. The facility failed to perform neurological checks and thoroughly assess this resident who hit his/her head during a fall.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview, the facility failed to consistently monitor bowel movements, behaviors, and side effects of medications for 5 of 5 residents reviewed for unnecessary medications (#6, #25, #28, #34, and #38), failed to consistently monitor blood sugar levels and have parameters for blood sugar monitoring for 1 of 5 residents reviewed for unnecessary medications (#6), and failed to monitor the effectiveness of an antibiotic for 1 of 5 residents reviewed for unnecessary medications (#38).

Findings included:

- The signed Physician's Order Sheet (POS) for resident #6 dated 6/12/14 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of

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language and communication and fragmentation of thought), constipation (difficulty passing stools), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).
The annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 3/28/14 revealed the resident had a BIMS score of 9 (moderate cognitive impairment). He/she had hallucinations (sensing things while awake that appear to be real, but the mind created), and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), did not exhibit verbal or physical behaviors, received injections, insulin, antipsychotic (medication to treat psychosis--any major mental disorder characterized by a gross impairment in reality testing), antianxiety (medication to treat anxiety--mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and antidepressant (medication to treat symptoms of depression--abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medication 7 of 7 days of the look back period.

The Care Area Assessment (CAA) for psychotropic drug use dated 4/9/14 revealed the resident had a long history of mental illness starting at age 16 and required psychotropic medications to control symptoms of the illness such as depression and psychosis as well as behaviors these caused. He/she needed monitoring for the effectiveness of the medications as well as for adverse side effects of

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the medications.

The care plan updated 7/4/14 revealed the resident received daily doses of psychotropic medications that had the potential for constipation. Nursing staff administered Colace (a stool softner) per physician's orders, monitored blood glucose levels per physician's orders, provided dietary fiber as needed, monitored for signs and symptoms of high and low blood sugar, and checked the resident's blood sugar if any signs and symptoms of high or low blood sugar were present.

The care plan updated 7/4/14 revealed the resident received daily doses of medications that had black box warnings and needed staff to monitor for signs or symptoms of adverse reactions. Staff encouraged him/her to remain compliant with medications and lab draws, staff monitored for signs or symptoms of adverse effects related to medications, and provided medications per physician's orders.

The July 2014 POS revealed orders for Abilify (an antipsychotic medication) 30 milligrams (mg) by mouth (PO) every morning for schizophrenia ordered 7/25/10, Zoloft (an antidepressant medication) 100 mg 2 tablets PO daily for depression ordered 8/27/08, Clozapine (an antipsychotic medication) 100 mg PO twice a day for schizophrenia ordered 1/26/13, Clozapine 100 mg 2 tablets PO at bedtime for schizophrenia ordered 1/26/13, Clonazepam (an antianxiety medication) 1 mg PO twice a day for schizophrenia ordered 1/26/13, and Haloperidol (an antipsychotic medication) 5 mg PO three times a day as needed (PRN) for agitation and psychosis ordered 6/3/10.

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The April 2014 behavior charting revealed inconsistent and inaccurate charting. Nine of 30 day and 1 of 30 evening shifts lacked behavior monitoring documentation. Thirty of 30 night and evening shifts lacked side effect monitoring documentation and 14 of 30 day shifts lacked side effect monitoring documentation. Twenty four of 30 days and 7 of 30 evening had inaccurate side effect monitoring documentation.

The May 2014 behavior charting revealed inconsistent and inaccurate charting. One of 31 days lacked behavior monitoring documentation. Thirty-one of 31 evening and night shifts lacked documentation for side effect monitoring. Three of 31 day shifts lacked documentation for side effect monitoring. Twenty eight of 31 day shifts had inaccurate side effect documentation.

The June 2014 behavior charting revealed inconsistent and inaccurate charting. Nine of 30 days lacked behavior monitoring documentation. Thirty of 30 night and evening shifts lacked documentation or side effect monitoring, 12 of 30 day shifts lacked documentation for side effect monitoring and 18 of 30 day shifts had inaccurate documentation.

The July 2014 behavior charting revealed inconsistent and inaccurate charting. Two of 13 days lacked behavior monitoring documentation and side effect monitoring. Eleven of 13 days had inaccurate side effect documentation. The staff documented the plus sign (+) in the box for side effects and the legend for potential side effects indicated side effects were identified with

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numbers. Thirteen of 13 night and evening shifts lacked charting for side effects.

The April 2014 Medication Administration Record (MAR) lacked documentation of a blood sugar at 6:00 A.M. on 4/1/14 and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for April 2014 revealed the facility failed to monitor bowel movements for the resident on 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, 4/25/14, 4/28/14, 4/29/14, and 4/30/14.

The May 2014 MAR lacked documentation of a blood sugar at 6:00 A.M. on 5/1/14 and at 4:30 P.M. on 5/31/14, and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for May 2014 revealed the facility failed to monitor bowel movements for the resident on 5/1/14, 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14.

The June 2014 MAR lacked documentation of a blood sugar at 4:30 P.M. and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for June 2014 revealed the facility failed to monitor bowel movements for the resident on 6/10/14, 6/11/14, 6/18/14, 6/19/14, 6/20/14, 6/22/14, 6/23/14, 6/24/14, and 6/25/14.

The July 2014 Treatment Administration Record (TAR) and the POS lacked parameters for acceptable blood sugar levels.

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The July 2014 POS revealed and order for blood sugar monitoring twice a day, dated 9/23/08 and Novolin N (insulin) 5 units subcutaneous (beneath the skin) (SQ) every morning and 3 units SQ every evening ordered 6/1/97.

The July 2014 POS revealed an order for Colace 100 mg capsules 2 capsules PO at bedtime for constipation dated 6/1/97.

Review of the bowel charting for July 1 through (-) 10, 2014 revealed the facility failed to monitor bowel movements for the resident on 7/9/14 and 7/10/14.

On 7/14/14 at 3:17 P.M. the resident participated in an activity in the living room.

On 7/14/14 at 4:47 P.M. the resident sat in a chair at the nurse's desk and talked to him/herself.

Interview on 7/14/14 at 2:39 P.M. with direct care staff Q revealed all 3 shifts asked the residents if they had a bowel movement and charted it in the bowel movement book. If a resident did not have a bowel movement for a few days he/she reported it to the nurse and direct care staff reported observed behaviors to the nurse and they charted this.

Interview on 7/14/14 at 2:41 P.M. with licensed nursing staff H revealed all staff looked at the bowel charting and was responsible for making sure it was completed. He/she acknowledged there were many holes in the charting and the psychotropic medications caused constipation. Licensed nursing staff H reported he/she charted

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(+) if a resident had side effects to medications but did not specify what side effects they had. He/she acknowledged there were no parameters for resident #6's blood sugars. He/she used nursing judgement to decide to give the insulin or not and called the doctor if he/she was not sure.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed he/she believed nursing staff charted (+) on the side effect line of the behavior monitoring document in error. He/she stated staff monitored side effects via observation of the resident and by the AIMS (Abnormal Involuntary Movement Scale) completed every 6 months but acknowledged there was no daily documentation of side effect monitoring. He/she revealed the evening shift completed the bowel monitoring sheet, if day shift knew a resident had a bowel movement they recorded it and evenings filled in the gaps. The nurses monitored that sheet and made sure it was filled out. He/she acknowledged some of the antipsychotic medications caused constipation.

Interview on 7/15/14 at 10:49 A.M. with administrative nursing staff D revealed there should be parameters for blood sugars on the POS, MAR, or TAR.

The facility failed to consistently monitor for the effectiveness of and the side effects of medications this resident received.

- The signed Physician's Order Sheet (POS) for resident #38 dated 6/12/14 revealed diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety

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disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 9/13/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and had no behaviors. He/she received antipsychotic medication (medications to treat psychosis-any major mental disorder characterized by a gross impairment in reality testing), antidepressant medication (medication to treat depression-abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypnotic medication (medication that induced sleep) 7 of 7 days of the look back period.

The Care Area Assessment (CAA) for psychotropic drug use dated 9/27/13 revealed the resident had chronic mental illness for which he/she received psychotropic medications. He/she needed monitoring for the effectiveness of these medications and needed monitoring for the side effects of these medications. Interventions that prevented or alleviated his/her depression, anxiety, and insomnia (inability to sleep) would be watched for and utilized.

The quarterly MDS 3.0 with an ARD of 6/6/14 revealed the resident had a BIMS score of 15 and had no behaviors. The resident received antipsychotic medication, antianxiety medication (medication to treat anxiety-mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), antidepressant medication, and hypnotic medication 7 of 7 days of the look back period.

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The care plan last reviewed 3/10/14 revealed the resident had an altered mood state and had a long history of mental illness with severe bouts of depression and isolating behavior. Nursing staff administered medications as ordered by the physician, educated the resident regarding the medications, informed the resident of risks versus benefits of taking his/her medications if he/she refused them, monitored for effectiveness of psychotropic medications on an ongoing basis and documented at least quarterly, informed the physician of the ineffectiveness of medications, monitored side effects to medications during interactions and informed the physician of adverse side effects, assisted the resident in making appropriate decisions, and discussed consequences of poor decisions, reassured the resident of his/her safety in the facility, and encouraged the resident to utilize coping skills when he/she was anxious.

The care plan updated 7/6/14 revealed the resident had an upper respiratory infection (URI) and received Levaquin (an antibiotic), Mucinex (a medication to thin mucous), and Duoneb breathing treatments (an inhaled medication to open the airways) as needed (PRN). Staff encouraged proper hand washing and covering of the face when the resident coughed and sneezed to prevent the spread of URI, offered a warm pack for the face to treat symptoms of nasal congestion, encouraged adequate hydration, encouraged drinking warm beverages, discouraged exposure to cold dry air, auscultated lungs as needed for complaints of shortness of breath or audible wheezes, recorded any findings, monitored the resident's temperature every shift and for 72 hours following antibiotic therapy and

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recorded this, monitored for adverse side effects of the antibiotic and monitored and recorded lung sounds every shift.

The July 2014 POS revealed the resident had orders for Mucinex 400 milligrams (mg) by mouth (PO) twice a day for 10 days dated 7/4/14, Levaquin 750 mg PO daily for a URI for 7 days dated 7/7/14, and Duoneb 3 milliliters (ml) by nebulizer every 4 hours PRN dated 7/6/14.

Nurse's notes dated 7/4/14 at 9:00 A.M. revealed the resident felt like he/she was drowning in his/her own fluids. Staff obtained an order to send the resident to the emergency room.

A nurse's note on 7/4/14 at 11:00 A.M. revealed the hospital admitted the resident with pneumonia (inflammation of the lungs).

A nurse's note on 7/6/14 at 3:30 P.M. revealed the resident returned to the facility, was treated with levaquin, and would continue treatment for 7 more days.

The clinical record lacked documentation of the resident's temperature and lung sounds on the 7/9/14 shift.

A nurse's note on 7/10/14 at 7:30 A.M. revealed the resident left the facility to go on an overnight pass. The record lacked documentation of the resident's temperature and lung sounds.

A nurse's note on 7/11/14 at 7:30 P.M. revealed the resident returned to the facility.

Record review on 7/14/14 at 10:00 A.M. revealed no further assessment of the resident's

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temperature, lung sounds, or respiratory condition.

The July 2014 POS revealed orders for Cymbalta (an medication to treat depression) 60 mg PO daily for depression ordered 2/11/14, Buspar (a medication to treat anxiety) 10 mg PO three times a day for anxiety dated 2/11/14, Hydroxyzine (a medication to treat anxiety) 50 mg PO four times a day for anxiety ordered 2/11/4, Abilify (an antipsychotic medication) 15 mg PO at bedtime for schizophrenia dated 2/11/4, Melatonin (a medication given to aid in sleep) 3 mg tablets 3 tablets PO at bedtime for insomnia dated 2/11/14, Ambien (a medication to aid in sleep) 10 mg PO daily for better sleep ordered 4/21/14, Olanzapine (an antipsychotic medication) 15 mg PO daily ordered 4/21/14, Olanzapine 5 mg PO twice a day PRN for anxiety ordered 5/17/14, and Invega Sustenna (an antipsychotic medication) 117 mg intramuscular every 4 weeks ordered 4/22/14.

The April 2014 behavior monitoring forms lacked documentation of side effect monitoring 4 of 30 day shifts and 30 of 30 evening and night shifts, and had inaccurate side effect monitoring documentation 26 of 30 days.

The May 2014 behavior monitoring forms lacked documentation 1 of 31 day shifts, lacked side effect monitoring 2 of 31 day shifts and 31 of 31 evening and night shifts, and had inaccurate side effect monitoring documentation 29 of 31 days.

The June behavior monitoring forms lacked documentation 10 of 30 day shifts and 1 of 30 evening shifts, lacked side effect monitoring for 25 of 30 day shifts and 30 of 30 evening and night

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shifts, and had inaccurate side effect monitoring documentation 5 of 30 days.

The July 2014 behavior monitoring forms lacked documentation 2 of 13 days, lacked side effect monitoring for 2 of 13 days and 11 of 13 evenings and nights, and 8 of 13 days had inaccurate side effect monitoring. The staff documented the plus sign (+) in the box for side effects and the legend for potential side effects indicated side effects were identified with numbers.

Review of the bowel charting documents for April 2014 revealed the facility failed to monitor bowel movements for the resident on 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, 4/25/14, 4/28/14, 4/29/14, and 4/30/14.

Review of the bowel charting documents for May 2014 revealed the facility failed to monitor bowel movements for the resident on 5/1/14, 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14.

Review of the bowel charting documents for June 2014 revealed the facility failed to monitor bowel movements for the resident on 6/10/14, 6/11/14, 6/18/14, 6/19/14, 6/20/14, 6/22/14, 6/23/14, 6/24/14, and 6/25/14.

Review of the bowel charting documents for July 2014 revealed the facility failed to monitor bowel movements for the resident on 7/9/14 and 7/10/14.

On 7/14/14 at 7:33 A.M. the resident slept in bed.

On 7/15/14 at 10:15 A.M. the resident prepared to

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leave the facility for an appointment with staff.

Interview on 7/14/14 at 2:39 P.M. direct care staff Q revealed all 3 shifts asked the residents if they had a bowel movement and this was charted in the bowel movement book. If a resident did not have a bowel movement for a few days he/she reported it to the nurse and direct care staff Q reported observed behaviors to the nurse and they charted this.

Interview on 7/14/14 at 2:41 P.M. with licensed nursing staff H revealed all staff looked at the bowel charting and was responsible for making sure it was completed. He/she acknowledged there were many holes in the charting and the psychotropic medications caused constipation. Licensed nursing staff H reported he/she charted (+) if a resident had side effects to medications but did not specify what side effects they had.

Interview on 7/15/14 at 8:41 A.M. with licensed nursing staff H revealed resident #38 received an antibiotic from 7/7/14 and finished 7/13/14 and acknowledged there was no continued monitoring of the residents lungs or temperature after the resident returned from his/her overnight pass on 7/11/14.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed he/she believed nursing staff charted (+) on the side effect line of the behavior monitoring document in error. He/she stated side effects were monitored via observation of the resident and by the AIMS (Abnormal Involuntary Movement Scale) completed every 6 months but acknowledged there was no daily documentation of side effect monitoring. He/she revealed the evening shift

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completed the bowel monitoring sheet, if day shift knew a resident had a bowel movement they recorded it and evenings filled in the gaps, and the nurses monitored that sheet and made sure it was filled out. He/she acknowledged some of the antipsychotic medications caused constipation and expected staff to monitor all medications as care planned for their effectiveness.

The facility failed to effectively monitor the effectiveness of and the side effects of medications for this resident.

- Resident #25's annual Minimum Data Set 3.0 (MDS) assessment dated 5/30/14 recorded the resident was unable to complete a Brief Interview for Mental Status which indicated the resident's cognition was impaired. The MDS recorded the resident required limited assistance with activities of daily living such as, mobility, dressing, toilet use and personal hygiene, and received anti-psychotic (mediation used for mental illness (psychosis) anti-anxiety, (mediation used to alleviate stress) and anti-depressant (mediation used to alleviate feelings of sadness).

The annual 6/13/14 Care Area Assessment (CAA) for Mood state recorded, the resident had schizoid-affective disorder (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction) and received medications to

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control mood swings and required staff to monitor medications for effectiveness as well as potential unwanted side effects.

Review of the July 2014 Physician's Order Sheet revealed the resident received the anti-depressant medications: buspiron, miratzapine; the anti-psychotic medications fluphenazin, paliperidone, risperdal, risperdal consta, and Invega, and the anti-anxiety medication lorazepam.

According to Lexi-comps Drug Reference Handbook 12th edition, all the residents psychotropic medications had a potential of causing constipation as a side effect.

Review of the monthly bowel monitoring logs from April 2014 through July 2014 provided by the facility revealed staff failed to consistently monitor the resident's bowel movements.

The following dates lacked documentation the resident had bowel movements 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, and 4/25/14 (duration of 6 days), 4/28/14, 4/29/14, 4/30/14, and 5/1/14 (duration of 4 days), 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14 (duration of 12 days), 6/22/14, 6/23/14, 6/24/14, and 6/25/14 (duration of 4 days) without a bowel movement.

The resident's care plan dated 7/10/14 documented the resident's use of psychotropic medications, however lacked documentation to monitor the resident bowel movements.

On 7/15/14 at 3:50 P.M. the resident sat in his/her room on the side of the bed arranging his/her

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shoes and said he/she was aware of some of the medications he/she took for depression and constipation. The resident stated staff did not routinely ask if he/she had a bowel movement or had any problem with his/her bowels.

On 7/10/14 at 8:30 A.M. administrative licensed nursing staff D acknowledged staff did not monitor residents' bowel movements on a consistent basis.

The facility did not provide a policy related to monitoring residents bowel movements.

The facility failed to monitor for the potential side effects related to bowel movements for this resident who received psychotropic medications.

- The quarterly Minimum Data Set 3.0 (MDS) dated 6/6/14 for resident #28 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. He/she displayed delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue) and verbal behavioral symptoms directed towards others. The resident required staff set up for bathing and required staff supervision for eating and personal hygiene. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (a medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of a diuretic medication (medication to

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promote the formation and excretion of urine) during the 7 day look back period.

The 10/11/13 Care Area Assessment (CAA) for psychotropic drug use revealed the resident received psychotropic medications which required monitoring for effectiveness of controlling or eliminating agitation, psychosis, and regulating mood. Staff also monitored for potential side effects.

The care plan with a revision date of 5/21/14 revealed the resident had behaviors that included superficial self harm, inability to recognize his/her own faults, attention seeking, and manipulation of staff and peers. The care plan also revealed the resident received psychotropic medications with potential side effects. Staff monitored for changes in mood and behaviors and reported changes to the physician as needed. Staff inquired daily regarding bowel movements (BM) and provided as needed medication per standing orders if the resident reported no BMs for 3 consecutive days.

The physician's order sheet signed on 6/12/14 revealed the following medications and start dates: 11/23/09 Abilify (an antipsychotic medication); 11/23/09 Trazadone (an antidepressant medication); 11/23/09 Lamictal (medication used for mood stabilization); 4/22/11 Seroquel (an antipsychotic medication); 11/15/11 Amitiza (medication used for the treatment of constipation; difficulty passing stools); 10/31/13 Docusate-Senna (medication used for the treatment of constipation).

The April, May, June, and July 1st through July 10th, 2014 Behavior Monitoring sheets revealed the following targeted behaviors for Abilify and

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Seroquel: cursed at staff due to redirection; attention seeking; inability to recognize own behaviors and pointed out faults of others; derogatory name calling of peers and staff; superficial self harm; and poor insight. Documentation on the form revealed the staff failed to follow the directions printed on the form for proper use. The directions read, "Enter target behavior in one of the behavior sections. Record the number of episodes by shift with initials. Enter the intervention code, outcome code, and side effects code with initials for each shift. See side two for list of behaviors and potential side effects. C = continuous; D = day; E = evening; N = nights." Staff inconsistently documented regarding monitoring for side effects and when documented at times used a plus sign instead of the codes listed per the form's directions. Also, the outcome section was inconsistently documented by staff even when the interventions listed showed a medication was used. The staff failed to include monitoring for the resident's Lamictal used for mood stabilization. The staff also failed to provide a specific targeted behavior with each medication or medication class to be able to evaluate the effectiveness of each medication.

Review of the BM monitoring logs from April 2014 through July 10, 2014 provided by the facility revealed staff failed to consistently monitor BMs. The following dates lacked documentation: 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, and 4/25/14 (duration of 6 days), 4/28/14, 4/29/14, 4/30/14, 5/1/14 (duration of 4 days), 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14 (duration of 12 days), 6/22/14, 6/23/14, 6/24/14, and 6/25/14 (duration of 4 days) without a bowel

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movement.

Observation on 7/10/14 at 4:08 P.M. revealed the resident sat in a chair at a dining room table actively participating in a group craft activity.

Interview on 7/14/14 at 4:04 P.M. with direct care staff R revealed the evening shift completed BM monitoring documentation. Staff asked the residents if they had a BM that day since most were independent. If the resident required assistance for toileting and had a BM then which ever staff assisted the resident, would document it on the BM log. Staff R reported many staff members were confused of whose responsibility it was to complete the BM documentation. Staff R stated staff should document on the BM log daily.

Interview on 7/14/14 at 4:22 P.M. with licensed nursing staff H revealed behavior monitoring sheets were developed by all licensed nursing staff. Staff H reported he/she always documented side effect monitoring with a plus sign due to the resident receiving scheduled psychotropic medications which always had the potential for side effects. He/she also stated he/she always wrote in interventions since the resident received scheduled medications and staff always provided one to one care and redirection throughout the shift. He/she acknowledged the targeted behaviors were not specific to each medication or medication class and therefore the monitoring for effectiveness of each medication was difficult. Staff H expected staff to complete BM monitoring daily and acknowledged there were multiple gaps in BM documentation.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed the facility

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held an inservice regarding proper use of the behavior monitoring forms. Staff D stated the nursing staff were to follow the directions on the forms. Staff D acknowledged the documentation of plus signs for side effects monitoring and reported he/she believed staff were getting confused on which line to document. Staff D said the staff monitored for side effects through the Abnormal Involuntary Movement Scale (AIMS) and observation. Staff completed the AIMS every 6 months but did not complete daily charting for side effects. Staff D expected staff to complete BM monitoring documentation daily by the afternoon shift. He/she stated if the day shift knew a resident had a BM then they would document it and the evening shift then filled in the gaps. Staff D expected the nurses to provide care per the care plan and monitor for the effectiveness of all medications.

The 3/09 policy provided by the facility regarding the behavior monitoring forms for antipsychotic medications revealed the forms were used to provide a quantitative, graphic method of charting behavior problems, interventions, and outcomes of the intervention.

The June 2013 policy provided by the facility regarding bowel and bladder management revealed the facility established a bowel regimen in conjunction with their medical director and/or each resident's attending physician.

The facility failed to consistently monitor the effectiveness of all the psychotropic medications and failed to consistently monitor bowel movements for this resident who received multiple psychotropic medications and medications for constipation.

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- The Quarterly Minimum Data Set 3.0 (MDS) dated 6/6/14 for resident #34 revealed a Brief Interview for Mental Status score of 12, indicating moderate cognitive impairment. He/she displayed hallucinations (sensing things while awake that appeared to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue). The resident was independent with bed mobility, transfer, walking in his/her room, walking in the corridor, locomotion on the unit, and locomotion off the unit. He/she required staff supervision for dressing, eating, and toilet use. He/she required staff supervision and set up assistance for personal hygiene and required staff set up assistance for bathing. The resident was always continent of bladder and bowel. The resident received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis--any major mental disorder characterized by a gross impairment in reality testing), and 7 doses of an antidepressant medication (a medication used for the treatment of depression--abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) during the 7 day look back period.

The 3/26/14 Care Area Assessment (CAA) for psychotropic medication use revealed the resident had the diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and depression (abnormal emotional state characterized by exaggerated feelings of

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sadness, worthlessness and emptiness) and required psychotropic medications to control his/her symptoms to tolerable and manageable levels. The resident required staff to monitor for therapeutic effects and for adverse side effects.

The care plan with a revision date of 5/26/14 revealed the resident displayed the following behaviors: hallucinations and delusions and threatening aggressive behaviors related to internal stimuli. The resident received daily doses of psychotropic medications related to his/her diagnoses. He/she received medications with a black box warning which required monitoring for adverse effects. Staff assessed for bowel movements (BMs) daily and provided as needed medications per standing orders if the resident had no BMs in 3 consecutive days.

The physician's order sheet signed 6/12/14 revealed the following medications and start dates: 10/23/09 Pristiq (an antidepressant medication); 10/23/09 Lamictal (medication used for mood stabilization); 10/23/09 Lorazepam (an antianxiety medication-- mental or emotional reaction characterized by apprehension, uncertainty and irrationalfear); 10/23/09 Clozaril (an antipsychotic medication); 6/17/10 Geodon (an antipsychotic medication); 11/10/11 Docusate Sodium (an anticonstipation medication--difficulty passing stools); and 12/1/11 Mirilax (an anticonstipation medication).

The April 2014, May 2014, June 2014, and July 1st through 10th, 2014 behavior monitoring forms revealed a targeted behavior of threatening aggressive behaviors related to internal stimuli for Lorazepam, Clozaril, and Geodon. The form also showed a targeted behavior of hallucinations for

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Clozaril and Geodon, and a targeted behavior of delusions for Geodon and Clozaril. Documentation on the form revealed the staff failed to follow the directions printed on the form for proper use. The directions read, "Enter target behavior in one of the behavior sections. Record the number of episodes by shift with initials. Enter the intervention code, outcome code and side effects code with initials for each shift. See side two for list of behaviors and potential side effects. C = continuous; D = day; E = evening; N = nights." Staff inconsistently documented monitoring for side effects and when documented at times used a plus sign instead of the codes listed per the form's directions. Also, the outcome section was inconsistently documented by staff even when the interventions listed showed a medication was used. The staff failed to include monitoring for the resident's Lamictal used for mood stabilization per the physician's order sheet. The staff also failed to provide a specific targeted behavior with each medication or medication class to be able to evaluate the effectiveness of each medication.

Review of the BM monitoring logs from April 2014 through July 2014 provided by the facility revealed staff failed to consistently monitor BMs. The following dates lacked documentation: 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, and 4/25/14(duration of 6 days), 4/28/14, 4/29/14, 4/30/14, 5/1/14 (duration of 4 days), 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14 (duration of 12 days), 6/22/14, 6/23/14, 6/24/14, and 6/25/14 (duration of 4 days).

Observation on 7/14/14 at 7:17 A.M. revealed the resident sat at a table in the dining room, ate

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breakfast, and conversed with his/her tablemates.

Interview on 7/14/14 at 4:04 P.M. with direct care staff R revealed the evening shift completed BM monitoring documentation. Staff asked the residents if they had a BM that day since most were independent. If the resident required assistance for toileting and had a BM then which ever staff assisted the resident would document it on the BM log. Staff R reported many staff members were confused of whose responsibility it was to complete the BM documentation. Staff R stated staff should document on the BM log daily.

Interview on 7/14/14 at 4:22 P.M. with licensed nursing staff H revealed behavior monitoring sheets were developed by all licensed nursing staff. Staff H reported he/she always documented side effect monitoring with a plus sign due to the resident received scheduled psychotropic medications which always had the potential for side effects. He/she also stated he/she always wrote in interventions since the resident received scheduled medications and staff always provided one to one care and redirection throughout the shift. He/she acknowledged the targeted behaviors were not specific to each medication or medication class and therefore the monitoring for effectiveness of each medication would be difficult. Staff H expected staff to complete BM monitoring daily and acknowledged there were multiple gaps in BM documentation.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed the facility held an inservice regarding proper use of the behavior monitoring forms. Staff D stated the nursing staff were to follow the directions on the forms. Staff D acknowledged the documentation

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F 329	Continued From page 39 of plus signs for side effect monitoring and reported he/she believed staff were getting messed up on which line to document on. Staff D said the staff monitored for side effects through the Abnormal Involuntary Movement Scale (AIMS) and observation. Staff completed the AIMS every 6 months but did not complete daily charting for side effects. Staff expected staff to complete BM monitoring documentation daily by the afternoon shift. He/she stated if the day shift knew a resident had a BM then they would document it and the evening shift then filled in the gaps. Staff D expected the nurses to provide care per the care plan and monitor for the effectiveness of all medications. The 3/09 policy provided by the facility regarding the behavior monitoring forms for antipsychotic medications revealed the forms were used to provide a quantitative, graphic method of charting behavior problems, interventions, and outcomes of the intervention. The June 2013 policy provided by the facility regarding bowel and bladder management revealed the facility established a bowel regimen in conjunction with their medical director and/or each resident's attending physician. The facility failed to consistently monitor the effectiveness of the psychotropic medications and failed to consistently monitor bowel movements for this moderately cognitively impaired resident that received multiple psychotropic medications and medications for constipation.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 40 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents with 1 main kitchen. Based on observation and interview the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 1 of 4 days on site of the survey. Findings included: - Observation on 7/9/14 at 8:52 A.M. revealed 2 cookie sheets full of partially thawed chicken breasts sat on a counter at room temperature. On 7/9/14 at 9:06 A.M. dietary staff DD stated he/she was getting ready to put seasoning on the chicken and put it in the oven. He/she revealed he/she took the chicken out of the freezer approximately 20 minutes ago. On 7/14/14 at 3:04 P.M. dietary staff EE revealed staff thawed food by setting it under running cold water or if it was partially thawed, he/she let it sit out in the sink at room temperature. On 7/14/14 at 4:33 P.M. administrative nursing	F 371		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 41 staff D revealed staff should thaw foods in the refrigerator, not at room temperature. The policy for thawing foods revised March 2009 provided by the facility revealed the recommended method of thawing food was under refrigeration. Other acceptable methods were as part of the cooking process, under portable water, or in a microwave. The facility failed to prepare food for residents in a way that prevented, reduced, or eliminated the risk of food borne illness.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview, the facility's consultant pharmacist failed to identify the facility's lack of consistent bowel monitoring and inconsistent and inaccurate behavior and side effect monitoring for 5 of 5 residents reviewed for unnecessary medications (#6, #25,	F 428		

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#28, #34, and #38), and failed to recognize the lack of parameters for blood sugar levels for 1 of 5 residents reviewed for unnecessary medications (#6).

Findings included:

- The signed Physician's Order Sheet (POS) for resident #6 dated 6/12/14 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), constipation (difficulty passing stools), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).
The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 3/28/14 revealed the resident had a BIMS score of 9 (moderate cognitive impairment). He/she had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), did not exhibit verbal or physical behaviors, received injections, insulin, antipsychotic (medication for the treatment of any major mental disorder characterized by a gross impairment in reality testing), antianxiety (medication for treatment of mental or emotional reaction characterized by apprehension, uncertainty and irrational fear)and antidepressant (medication for the treatment of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) medication 7 of 7 days of the look

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back period.
The Care Area Assessment (CAA) for psychotropic drug use dated 4/9/14 revealed the resident had a long history of mental illness starting at age 16 and required psychotropic medications to control symptoms of the illness such as depression and psychosis as well as behaviors these caused. He/she needed monitoring for the effectiveness of the medications as well as for adverse side effects of the medications.

The care plan updated 7/4/14 revealed the resident received daily doses of psychotropic medications that had the potential for constipation. Nursing staff administered Colace (a stool softner) per physician's orders, monitored blood glucose levels per physician's orders, provided dietary fiber as needed, staff monitored for signs and symptoms of high and low blood sugar, and checked the resident's blood sugar if any signs and symptoms of high or low blood sugar were present.

The July 2014 POS revealed orders for Abilify (an antipsychotic medication) 30 milligrams (mg) by mouth (PO) every morning for schizophrenia ordered 7/25/10, Zoloft (an antidepressant medication) 100 mg 2 tablets PO daily for depression ordered 8/27/08, Clozapine (an antipsychotic medication) 100 mg PO twice a day for schizophrenia ordered 1/26/13, Clozapine 100 mg 2 tablets PO at bedtime for schizophrenia ordered 1/26/13, Clonazepam (an antianxiety medication) 1 mg PO twice a day for schizophrenia ordered 1/26/13, and Haloperidol (an antipsychotic medication) 5 mg PO three times a day as needed (PRN) for agitation and psychosis ordered 6/3/10.

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The April 2014 behavior charting revealed inconsistent and inaccurate charting. Nine of 30 day shifts and 1 of 30 evening shifts lacked behavior monitoring documentation. Thirty of 30 night and evening shifts lacked side effect monitoring documentation and 14 of 30 day shifts lacked side effect monitoring documentation. Twenty four of 30 days and 7 of 30 evenings had inaccurate side effect monitoring documentation.

The May 2014 behavior charting revealed inconsistent and inaccurate charting. One of 31 day shifts lacked behavior monitoring documentation. Thirty-one of 31 evening and night shifts lacked documentation for side effect monitoring. Three of 31 day shifts lacked documentation for side effect monitoring. Twenty eight of 31 days had inaccurate side effect documentation.

The June 2014 behavior charting revealed inconsistent and inaccurate charting. Nine of 30 days lacked behavior monitoring documentation. Thirty of 30 night and evening shift lacked documentation for side effect monitoring, 12 of 30 day shifts lacked documentation for side effect monitoring and 18 of 30 day shifts had inaccurate documentation.

The July 2014 behavior charting revealed inconsistent and inaccurate charting. Two of 13 days lacked behavior monitoring documentation and side effect monitoring. Eleven of 13 days had inaccurate side effect documentation. The staff documented the plus sign (+) in the box for side effects and the legend for potential side effects indicated side effects were identified with

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numbers. Thirteen of 13 night and evening shifts lacked charting for side effects.

The April 2014 Medication Record Review (MAR) lacked documentation of a blood sugar at 6:00 A.M. on 4/1/14 and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for April 2014 revealed the facility failed to monitor bowel movements for the resident on 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, 4/25/14, 4/28/14, 4/29/14, and 4/30/14.

The May 2014 MAR lacked documentation of a blood sugar at 6:00 A.M. on 5/1/14 and at 4:30 P.M. on 5/31/14, and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for May 2014 revealed the facility failed to monitor bowel movements for the resident on 5/1/14, 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14.

The June 2014 MAR lacked documentation of a blood sugar at 4:30 P.M. and lacked parameters for acceptable blood sugar levels.

Review of the bowel charting for June 2014 revealed the facility failed to monitor bowel movements for the resident on 6/10/14, 6/11/14, 6/18/14, 6/19/14, 6/20/14, 6/22/14, 6/23/14, 6/24/14, and 6/25/14.

The July 2014 Treatment Administration Record (TAR) and the POS lacked parameters for acceptable blood sugar levels.

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The July 2014 POS revealed and order for blood sugar monitoring twice a day dated 9/23/08 and Novolin N (insulin) 5 units subcutaneous (beneath the skin) (SQ) every morning and 3 units SQ every evening ordered 6/1/97.

The July 2014 POS revealed an order for Colace 100 mg capsules 2 capsules PO at bedtime for constipation dated 6/1/97.

Review of the bowel charting documents for July 1 daily through July 10, 2014 revealed the facility failed to monitor bowel movements for the resident on 7/9/14 and 7/10/14.

The consultant pharmacist completed drug regimen reviews on 7/2/14, 6/4/14, 5/6/14, 4/2/14, 3/5/14, 2/12/14, 1/8/14, 12/4/13, 11/6/13, 10/2/13, 9/4/13, 8/7/13, 7/3/13, and unknown dates in June, May and April of 2013. The clinical record lacked documentation the consultant pharmacist recognized the facility's inadequate behavior, side effect, and bowel monitoring, and the lack of parameters for this residents blood sugar.

On 7/14/14 at 3:17 P.M. the resident participated in an activity in the living room.

On 7/14/14 at 4:47 P.M. the resident sat in a chair at the nurse's desk and talked to him/herself.

Interview on 7/14/14 at 2:41 P.M. with licensed nursing staff H revealed the director of nursing completed the pharmacy recommendations.

Interview on 7/15/14 at 11:29 A.M. administrative nursing staff D revealed he/she expected the pharmacy consultant to identify and report

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concerns to the facility.

Interview on 7/16/14 at 2:00 P.M. with consultant staff KK revealed he/she looked at medication paramenters usually and expected them to be listed. He/she had not reviewed the facility's behavior monitoring but believed it was reviewed by previous consultant pharmacists. He/she did advise staff on behavior and medication side effect monitoring and believed all residents on psychotropic medications should have behavior and side effect monitoring and consistent bowel monitoring.

The 12/15/01 policy provided by the facility regarding the drug regimen review revealed the consultant pharmacist visited the facility as required per state regulation to review the drug regimen. If a potential or actual problem needed to be communicated to the physician or director of nursing, the consultant pharmacist documented accordingly.

The consultant pharmacist failed to identify the facility's lack of consistent and accurate bowel, behavior, and side effect monitoring and lack of parameters for medications.

- The signed Physician's Order Sheet (POS) for resident #38 dated 6/12/14 revealed diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

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The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 9/13/13 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and had no behaviors. He/she received antipsychotic medication (medications to treat psychosis-any major mental disorder characterized by a gross impairment in reality testing), antidepressant medication (medication to treat depression-abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and hypnotic medication (medication that induced sleep) 7 of 7 days of the look back period.

The Care Area Assessment (CAA) for psychotropic drug use dated 9/27/13 revealed the resident had chronic mental illness for which he/she received psychotropic medications. He/she needed monitoring for the effectiveness of these medications and needed monitoring for the side effects of these medications. Interventions that prevented or alleviated his/her depression, anxiety, and insomnia (inability to sleep) would be watched for and utilized.

The quarterly MDS 3.0 with an ARD of 6/6/14 revealed the resident had a BIMS score of 15 and had no behaviors. The resident received antipsychotic medication, antianxiety medication (medication to treat anxiety-mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), antidepressant medication, and hypnotic medication 7 of 7 days of the look back period.

The care plan last reviewed 3/10/14 revealed the resident had an altered mood state and had a long history of mental illness with severe bouts of

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depression and isolating behavior. Nursing staff administered medications as ordered by the physician, educated the resident regarding the medications, informed the resident of risks versus benefits of taking his/her medications if he/she refused them, monitored for effectiveness of psychotropic medications on an ongoing basis and documented at least quarterly, informed the physician of the ineffectiveness of medications, monitored side effects to medications during interactions and informed the physician of adverse side effects, assisted the resident in making appropriate decisions, discussed consequences of poor decisions, reassured the resident of his/her safety in the facility, and encouraged the resident to utilize coping skills when he/she was anxious.

The July 2014 POS revealed orders for Cymbalta (an medication to treat depression) 60 mg PO daily for depression ordered 2/11/14, Buspar (a medication to treat anxiety) 10 mg PO three times a day for anxiety dated 2/11/14, Hydroxyzine (a medication to treat anxiety) 50 mg PO four times a day for anxiety ordered 2/11/4, Abilify (an antipsychotic medication) 15 mg PO at bedtime for schizophrenia dated 2/11/4, Melatonin (a medication given to aid in sleep) 3 mg tablets 3 tablets PO at bedtime for insomnia dated 2/11/14, Ambien (a medication to aid in sleep) 10 mg PO daily for better sleep ordered 4/21/14, Olanzapine (an antipsychotic medication) 15 mg PO daily ordered 4/21/14, Olanzapine 5 mg PO twice a day PRN for anxiety ordered 5/17/14, and Invega Sustenna (an antipsychotic medication) 117 mg intramuscular every 4 weeks ordered 4/22/14.

The April 2014 behavior monitoring forms lacked

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documentation of side effect monitoring 4 of 30 day shifts and 30 of 30 evening and night shifts, and had inaccurate side effect monitoring documentation 26 of 30 days.

The May 2014 behavior monitoring forms lacked documentation 1 of 31 day shifts, lacked side effect monitoring 2 of 31 day shifts and 31 of 31 evening and night shifts, and had inaccurate side effect monitoring documentation 29 of 31 days.

The June behavior monitoring forms lacked documentation 10 of 30 day shifts and 1 of 30 evening shifts, lacked side effect monitoring for 25 of 30 day shifts and 30 of 30 evening and night shifts, and had inaccurate side effect monitoring documentation 5 of 30 days.

The July 2014 behavior monitoring forms lacked documentation 2 of 13 day shift, lacked side effect monitoring for 2 of 13 day shifts and 11 of 13 evening and night shifts, and 8 of 13 days had inaccurate side effect monitoring. The staff documented the plus sign (+) in the box for side effects and the legend for potential side effects indicated side effects were identified with numbers.

Review of the bowel charting documents for April 2014 revealed the facility failed to monitor bowel movements for the resident on 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, 4/25/14, 4/28/14, 4/29/14, and 4/30/14.

Review of the bowel charting documents for May 2014 revealed the facility failed to monitor bowel movements for the resident on 5/1/14, 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14,

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F 428	Continued From page 51 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14. Review of the bowel charting documents for June 2014 revealed the facility failed to monitor bowel movements for the resident on 6/10/14, 6/11/14, 6/18/14, 6/19/14, 6/20/14, 6/22/14, 6/23/14, 6/24/14, and 6/25/14. Review of the bowel charting documents for July 2014 revealed the facility failed to monitor bowel movements for the resident on 7/9/14 and 7/10/14. Review of the monthly Drug Regimen Reviews dated 4/13, 5/13, 6/13, 7/3/13, 8/7/13, 9/4/13, 10/2/13, 11/6/13, 12/13, 1/8/14, 2/12/14, 3/5/14, 4/2/14, 5/6/14, 6/4/14, and 7/2/14 revealed no pharmacy recommendations regarding bowel monitoring, medication side effects or effectiveness. On 7/14/14 at 7:33 A.M. the resident slept in bed. On 7/15/14 at 10:15 A.M. the resident prepared to leave the facility for an appointment with staff. Interview on 7/14/14 at 2:41 P.M. with licensed nursing staff H revealed the director of nursing completed the pharmacy recommendations. Interview on 7/15/14 at 11:29 A.M. administrative nursing staff D revealed he/she expected the pharmacy consultant to identify and report concerns to the facility. Interview on 7/16/14 at 2:00 P.M. with consultant staff KK revealed he/she had not reviewed the facility's behavior monitoring but believed it was reviewed by previous consultant pharmacists.	F 428		

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F 428	Continued From page 52 He/she did advise staff on behavior and medication side effect monitoring and believed all residents on psychotropic medications should have behavior and side effect monitoring and consistent bowel monitoring. The 12/15/01 policy provided by the facility regarding the drug regimen review revealed the consultant pharmacist visited the facility as required per state regulation to review the drug regimen. If a potential or actual problem needed to be communicated to the physician or director of nursing, the consultant pharmacist documented accordingly. The consultant pharmacist failed to identify the facility's lack of consistent and accurate bowel, behavior, and side effect monitoring. - Resident #25's annual Minimum Data Set 3.0 (MDS) assessment dated 5/30/14 recorded the resident was unable to complete a Brief Interview for Mental Status which indicated the resident's cognition was impaired. The MDS recorded the	F 428		

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resident required limited assistance with activities of daily living such as, mobility, dressing, toilet use and personal hygiene, and received anti-psychotic (mediation used for mental illness (psychosis) anti-anxiety, (mediation used to alleviate stress) and anti-depressant (mediation used to alleviate feelings of sadness).

The annual 6/13/14 Care Area Assessment (CAA) for Mood state recorded, the resident had schizoid-affective disorder (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought, perception and emotional reaction) and received medications to control mood swings and required staff to monitor medications for effectiveness as well as potential unwanted side effects.
Review of the the July 2014 Physician Order Sheet (POS) revealed the resident received the anti-depressant medications: buspiron, miratzapine; the anti-psychotic medications fluphenazin, paliperidone, risperdal, risperdal consta, and Invega, and the anti-anxiety medication lorazepam.

According to Lexi-comps Drug Reference Handbook 12th edition, all the residents psychotropic medications had a potential of causing constipation as a side effect.

Review of the monthly bowel monitoring logs from April 2014 through July 2014 provided by the facility revealed staff failed to consistently monitor the resident's bowel movements.

The following dates lacked documentation of the resident bowel movements 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, and 4/25/14 (duration

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of 6 days), 4/28/14, 4/29/14, 4/30/14, and 5/1/14 (duration of 4 days), 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14 (duration of 12 days), 6/22/14, 6/23/14, 6/24/14, and 6/25/14 (duration of 4 days) without a bowel movement.

The resident's care plan dated 7/10/14 documented the resident's use of psychotropic medications, however lacked documentation to monitor the resident bowel movements.

Review of the Drug Regimen Review for 1/14, 2/14,3/14,4/14, 5/14, 6/14, revealed no pharmacy recommendations regarding side effect monitoring or bowel monitoring.

On 7/15/14 at 3:50 P.M. the resident sat in his/her room on the side of the bed arranging his/her shoes and said he/she was aware of some of the medications he/she took for depression and constipation. The resident stated staff did not routinely ask if he/she had a bowel movement or had any problem with his/her bowels.

On 7/10/14 at 8:30 A.M. administrative licensed nursing staff D acknowledged staff did not monitor resident's bowel movements on a consistent basis.
On 7/16/14 at 2:00 P.M. a telephone interview with the facility's pharmacy consultant KK acknowledged he/she expected the facility to monitor bowel moments for resident who received psychotropic and other mediations that could alter a resident's gastro-intestinal motility.

The 12/15/01 policy provided by the facility regarding the drug regimen review revealed the consultant pharmacist visited the facility as

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required per state regulation to review the drug regimen. If a potential or actual problem needed to be communicated to the physician or director of nursing, the consultant pharmacist documented accordingly.

The facility failed to monitor medication effectiveness and/or potential side effects related to bowel movements for this resident who received psychotropic medications.

- The quarterly Minimum Data Set 3.0 (MDS) dated 6/6/14 for resident #28 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. He/she displayed delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue) and verbal behavioral symptoms directed towards others. The resident required staff set up for bathing and required staff supervision for eating and personal hygiene. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (a medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of a diuretic medication (medication to promote the formation and excretion of urine) during the 7 day look back period.

The 10/11/13 Care Area Assessment (CAA) for psychotropic drug use revealed the resident received psychotropic medications which required monitoring for effectiveness of controlling or

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eliminating agitation, psychosis, and regulating mood. Staff also monitored for potential side effects.

The care plan with a revision date of 5/21/14 revealed the resident had behaviors that included superficial self harm, inability to recognize his/her own faults, attention seeking, and manipulation of staff and peers. The care plan also revealed the resident received psychotropic medications with potential side effects. Staff monitored for changes in mood and behaviors and reported changes to the physician as needed. Staff inquired daily regarding bowel movements (BM) and provided as needed medication per standing orders if the resident reported no BMs for 3 consecutive days.

The physician's order sheet signed on 6/12/14 revealed the following medications and start dates: 11/23/09 Abilify (an antipsychotic medication); 11/23/09 Trazadone (an antidepressant medication); 11/23/09 Lamictal (medication used for mood stabilization); 4/22/11 Seroquel (an antipsychotic medication); 11/15/11 Amitiza (medication used for the treatment of constipation; difficulty passing stools); 10/31/13 Docusate-Senna (medication used for the treatment of constipation).

The April, May, June, July 1st through (-) 10th, 2014 Behavior Monitoring sheet revealed the following targeted behaviors for Abilify and Seroquel: cursed at staff due to redirection; attention seeking; inability to recognize own behaviors and pointed out faults of others; derogatory name calling of peers and staff; superficial self harm; and poor insight. Documentation on the form revealed the staff failed to follow the directions printed on the form

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for proper use. The directions read, "Enter target behavior in one of the behavior sections. Record the number of episodes by shift with initials. Enter the intervention code, outcome code, and side effects code with initials for each shift. See side two for list of behaviors and potential side effects. C = continuous; D = day; E = evening; N = nights." Staff inconsistently documented regarding monitoring for side effects and when documented at times used a plus sign instead of the codes listed per the form's directions. Also, the outcome section was inconsistently documented by staff even when the interventions listed showed a medication was used. The staff failed to include monitoring for the resident's Lamictal used for mood stabilization. The staff also failed to provide a specific targeted behavior with each medication or medication class to be able to evaluate the effectiveness of each medication.

Review of the BM monitoring logs from April 2014 through July 10,2014 provided by the facility revealed staff failed to consistently monitor BMs. The following dates lacked documentation: 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, and 4/25/14 (6 day duration), 4/28/14, 4/29/14, 4/30/14, and 5/1/14 (4 day duration) , 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, and 5/14/14 (12 day duration), 6/22/14, 6/23/14, 6/24/14, and 6/25/14 (4 day duration) without a bowel movement.

The Drug Regimen Review revealed the consultant pharmacist reviewed the resident's clinical record on the following dates: 4/3/13, 5/8/13, 6/12/13, 7/3/13, 8/7/13, 9/4/13, 10/2/13,

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11/6/13, 12/4/13, 1/8/14, 2/12/14, 3/5/14, 4/2/14, 5/7/14, 6/4/14, and 7/2/14. Review of the pharmacist's notes revealed he/she failed to recognize and report to the facility their failure to provide consistent behavior and bowel monitoring.

Observation on 7/10/14 at 4:08 P.M. revealed the resident sat in a chair at the dining room table actively participating in a group craft activity.

Interview on 7/14/14 at 4:04 P.M. with direct care staff R revealed the evening shift completed BM monitoring documentation. Staff asked the residents if they had a BM that day since most were independent. If the resident required assistance for toileting and had a BM then which ever staff assisted the resident, would document it on the BM log. Staff R reported many staff members were confused of whose responsibility it was to complete the BM documentation. Staff R stated staff should document on the BM log daily.

Interview on 7/14/14 at 4:22 P.M. with licensed nursing staff H revealed behavior monitoring sheets were developed by all licensed nursing staff. Staff H reported he/she always documented side effect monitoring with a plus sign due to the resident receiving scheduled psychotropic medications which always had the potential for side effects. He/she also stated he/she always wrote in interventions since the resident received scheduled medications and staff always provided one to one care and redirection throughout the shift. He/she acknowledged the targeted behaviors were not specific to each medication or medication class and therefore the monitoring for effectiveness of each medication was difficult. Staff H expected staff to complete BM monitoring

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daily and acknowledged there were multiple gaps in BM documentation.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed the facility held an inservice regarding proper use of the behavior monitoring forms. Staff D stated the nursing staff were to follow the directions on the forms. Staff D acknowledged the documentation of plus signs for side effects monitoring and reported he/she believed staff were getting confused on which line to document. Staff D said the staff monitored for side effects through the Abnormal Involuntary Movement Scale (AIMS) and observation. Staff completed the AIMS every 6 months but did not complete daily charting for side effects. Staff D expected staff to complete BM monitoring documentation daily by the afternoon shift. He/she stated if the day shift knew a resident had a BM then they would document it and the evening shift then filled in the gaps. Staff D expected the nurses to provide care per the care plan and monitor for the effectiveness of all medications. Staff D reported he/she expected the consultant pharmacist to identify and report concerns to the facility. He/she expected the facility staff to follow up on any pharmacy recommendations.

Interview on 7/16/14 at 2:00 P.M. with consultant pharmacist KK revealed he/she did advise the facility staff on behavior and side effect monitoring. Consultant staff KK expected staff to provide behavior monitoring on all residents on psychotropic medications with side effects included. He/she did not expect behavior monitoring for mood stabilizers. Consultant staff KK expected the staff to provide consistent bowel monitoring.

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The 12/15/01 policy provided by the facility regarding the drug regimen review revealed the consultant pharmacist visited the facility as required per state regulation to review the drug regimen. If a potential or actual problem needed to be communicated to the physician or director of nursing, the consultant pharmacist documented accordingly.

The consultant pharmacist failed to recognize and report to the facility their failure to consistently monitor the effectiveness of all the psychotropic medications and their failure to consistently monitor bowel movements for this resident who received multiple psychotropic medications and medications for constipation.

- The Quarterly Minimum Data Set 3.0 (MDS) dated 6/6/14 for resident #34 revealed a Brief Interview for Mental Status score of 12, indicating moderate cognitive impairment. He/she displayed hallucinations (sensing things while awake that appeared to be real, but the mind created); delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue). The resident was independent with bed mobility, transfer, walking in his/her room, walking in the corridor, locomotion on the unit, and locomotion off the unit. He/she required staff supervision for dressing, eating, and toilet use. He/she required staff supervision and set up assistance for personal hygiene and required staff set up assistance for bathing. The resident was always continent of bladder and bowel. The resident received 7 doses of an

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antipsychotic medication (medication used for the treatment of psychosis-- any major mental disorder characterized by a gross impairment in reality testing), and 7 doses of an antidepressant medication (a medication used for the treatment of depression--abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) during the 7 day look back period.

The 3/26/14 Care Area Assessment (CAA) for psychotropic medication use revealed the resident had the diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and required psychotropic medications to control his/her symptoms to tolerable and manageable levels. The resident required staff to monitor for therapeutic effects and for adverse side effects.

The care plan with a revision date of 5/26/14 revealed the resident displayed the following behaviors: hallucinations and delusions and threatening aggressive behaviors related to internal stimuli. The resident received daily doses of psychotropic medications related to his/her diagnoses. He/she received medications with a black box warning which required monitoring for adverse effects. Staff assessed for bowel movements (BMs) daily and provided as needed medications per standing orders if the resident had no BMs in 3 consecutive days.

The physician's order sheet signed 6/12/14

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revealed the following medications and start dates: 10/23/09 Pristiq (an antidepressant medication); 10/23/09 Lamictal (medication used for mood stabilization); 10/23/09 Lorazepam (an antianxiety medication-- mental or emotional reaction characterized by apprehension, uncertainty and irrational fear); 10/23/09 Clozaril (an antipsychotic medication); 6/17/10 Geodon (an antipsychotic medication); 11/10/11 Docusate Sodium (an anticonstipation medication-- difficulty passing stools); and 12/1/11 Mirilax (an anticonstipation medication).

The April 2014, May 2014, June 2014, and July 1-10, 2014 behavior monitoring forms revealed a target behavior of threatening aggressive behaviors related to internal stimuli for Lorazepam, Clozaril, and Geodon. The form also showed a targeted behavior of hallucinations for Clozaril and Geodon, and a targeted behavior of delusions for Geodon and Clozaril. Documentation on the form revealed the staff failed to follow the directions printed on the form for proper use. The directions read, "Enter target behavior in one of the behavior sections. Record the number of episodes by shift with initials. Enter the intervention code, outcome code and side effects code with initials for each shift. See side two for list of behaviors and potential side effects. C = continuous; D = day; E = evening; N = nights." Staff inconsistently documented monitoring for side effects and when documented at times used a plus sign instead of the codes listed per the form's directions. Also, the outcome section was inconsistently documented by staff even when the interventions listed showed a medication was used. The staff failed to include monitoring for the resident's Lamictal used for

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mood stabilization per the physician's order sheet. The staff also failed to provide a specific targeted behavior with each medication or medication class to be able to evaluate the effectiveness of each medication.

Review of the BM monitoring logs from April 2014 through July 2014 provided by the facility revealed staff failed to consistently monitor BMs. The following dates lacked documentation: 4/20/14, 4/21/14, 4/22/14, 4/23/14, 4/24/14, 4/25/14, 4/28/14, 4/29/14, 4/30/14, 5/1/14, 5/3/14, 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 5/10/14, 5/11/14, 5/12/14, 5/13/14, 5/14/14, 6/10/14, 6/11/14, 6/18/14, 6/19/14, 6/20/14, 6/22/14, 6/23/14, 6/24/14, 6/25/14, 7/9/14, and 7/10/14.

The Drug Regimen Review revealed the consultant pharmacist reviewed the resident's clinical record on the following dates: 4/3/13, 5/8/13, 6/12/13, 7/3/13, 8/8/13, 9/4/13, 10/2/13, 11/6/13, 12/4/13, 1/8/14, 2/12/14, 3/5/14, 4/2/14, 5/6/14, 6/4/14, and 7/2/14. Review of the pharmacist's notes revealed he/she failed to recognize and report to the facility their failure to provide consistent behavior and bowel monitoring.

Observation on 7/14/14 at 7:17 A.M. revealed the resident sat at a table in the dining room, ate breakfast, and conversed with his/her tablemates.

Interview on 7/14/14 at 4:04 P.M. with direct care staff R revealed the evening shift completed BM monitoring documentation. Staff asked the residents if they had a BM that day since most were independent. If the resident required assistance for toileting and had a BM then which

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ever staff assisted the resident would document it on the BM log. Staff R reported many staff members were confused of whose responsibility it was to complete the BM documentation. Staff R stated staff should document on the BM log daily.

Interview on 7/14/14 at 4:22 P.M. with licensed nursing staff H revealed behavior monitoring sheets were developed by all licensed nursing staff. Staff H reported he/she always documented side effect monitoring with a plus sign due to the resident receiving scheduled psychotropic medications which always had the potential for side effects. He/she also stated he/she always wrote in interventions since the resident received scheduled medications and staff always provided one to one care and redirection throughout the shift. He/she acknowledged the targeted behaviors were not specific to each medication or medication class and therefore the monitoring for effectiveness of each medication would be difficult. Staff H expected staff to complete BM monitoring daily and acknowledged there were multiple gaps in BM documentation.

Interview on 7/15/14 at 9:39 A.M. with administrative nursing staff D revealed the facility held an inservice regarding proper use of the behavior monitoring forms. Staff D stated the nursing staff were to follow the directions on the forms. Staff D acknowledged the documentation of plus signs for side effects monitoring and reported he/she believed staff were getting messed up on which line to document on. Staff D said the staff monitored for side effects through the Abnormal Involuntary Movement Scale (AIMS) and observation. Staff completed the AIMS every 6 months but did not complete daily charting for side effects. Staff d expected staff to

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complete BM monitoring documentation daily by the afternoon shift. He/she stated if the day shift knows that a resident had a BM then they would document it and the evening shift then filled in the gaps. Staff D expected the nurses to provide care per the care plan and monitor for the effectiveness of all medications. Staff D reported he/she expected the consultant pharmacist to identify and report concerns to the facility. He/she expected the facility staff to follow up on any pharmacy recommendations.

Interview on 7/16/14 at 2:00 P.M. with consultant pharmacist KK revealed he/she did advise the facility staff on behavior and side effect monitoring. Consultant staff KK expected staff to provide behavior monitoring to all residents on psychotropic medications with side effects included. He/she did not expect behavior monitoring for mood stabilizers. Consultant staff KK expected the staff to provide consistent bowel monitoring.

The 12/15/01 policy provided by the facility regarding the drug regimen review revealed the consultant pharmacist visited the facility as required per state regulation to review the drug regimen. If a potential or actual problem needed to be communicated to the physician or director of nursing, the consultant pharmacist documented accordingly.

The consultant pharmacist failed to identify and report to the facility their failure to consistently monitor the effectiveness of all the psychotropic medications and their failure to consistently monitor bowel movements for this moderately cognitively impaired resident that received

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. Based on observation, record review, and interview the facility failed to ensure the medication carts, treatment carts, and medication room were free of expired medication and treatment products.

Findings included:

- Observation from the initial tour on 7/9/14 at 8:51 A.M. revealed a vial of tuberculosis vaccine with an opened date of 4/23/14 located in the medication room fridge.

Observation from the initial tour on 7/9/14 at approximately 9:00 A.M. revealed the medication cart referred to by staff as the "regular medication cart" contained a bottle of Melatonin 10 milligrams used for sleep with an expiration date of 1/26/14.

Interview on 7/9/14 at 8:51 A.M. with licensed nursing staff H revealed the staff should discard the tuberculosis vaccine vial 30 days after the open date.

Interview on 7/9/14 at 9:15 A.M. with direct care staff P revealed the staff checked the medication carts weekly for expired medications.

Interview on 7/15/14 at 11:28 A.M. with administrative nursing staff D revealed the nursing staff was responsible for monitoring for expired medications. Staff D expected staff to remove the expired medications from the medication cart, treatment carts, and medication

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 68 room. The 12/15/01 policy provided by the facility regarding the storage of medications revealed medications shall not be kept on hand after the expiration date on the label or container. The facility failed to timely discard expired medications.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E596	A. BUILDING _____ B. WING _____	07/18/2014

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F 441	Continued From page 69	F 441		

hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 11 residents. Based on observation, record review, and interview the facility failed to maintain an infection control program and failed to follow proper infection control procedures for cleaning residential rooms.

Findings included:

- Observation of a room cleaning on 7/15/14 at 8:49 A.M. by housekeeping staff Y revealed he/she failed to clean and/or disinfect the call lights and light switches. Staff Y wore gloves and cleaned the toilet seat and base of toilet, and failed to change his/her gloves prior to starting to sweep the bathroom and placing a new roll of toilet paper on the back of the toilet. Staff Y sprayed AIR x 75 (a cleaning product) onto a clean rag, wiped down the resident's head and foot boards on the bed and the bedside table. The surfaces remained wet for 1 minute prior to drying. Staff Y sprayed the sink and hand rails in the bathroom and then wiped them with a dry rag.

The manufacture guidelines for AIR x 75 revealed the wet time was 3 minutes.

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F 441	Continued From page 70	F 441		

Interview on 7/15/14 at 9:12 A.M. with housekeeping staff Y revealed the cleaning staff only cleaned and sanitized the call lights and light switches weekly. Staff Y also reported the housekeeping staff did not change their gloves after cleaning the toilet. He/she also stated the staff's goal was to follow the manufacturer's instructions for the proper use of the cleaning products used in the facility.

Interview on 7/15/14 at 10:50 A.M. with administrative nursing staff D revealed he/she expected the housekeeping staff to change gloves after cleaning the toilets and to wash hands appropriately. Staff D expected the housekeeping staff to clean and sanitize the call lights and light switches with deep cleaning of the rooms and not with daily cleaning. Staff D was unsure of the facility's policy for cleaning of call lights and light switches. Staff D reported he/she expected the housekeeping staff to follow the manufacturer's instructions for cleaning products.

The 1/1/2000 policy provided by the facility regarding daily patient room cleaning revealed infection control was the goal of an effective room cleaning technique.

The facility failed to follow the manufacturer's instructions for cleaning products, failed to change gloves after cleaning the toilet, and failed to clean frequently used surfaces of call lights and light switches in the resident's room.

- Review of the infection control log provided by the facility on 7/15/14 at approximately 11:00 A.M. revealed the forms used by the facility were not

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F 441	Continued From page 71	F 441		

completed for any month from 4/2013 to 7/2014. The forms lacked information regarding completion of antibiotic use, if the infection was facility acquired, and if follow up was completed.

Interview on 7/10/14 at 11:24 A.M. with administrative nursing staff D revealed he/she reported the infection control logs were not done well, and the facility was behind on tracking and trending infections.

Interview on 7/15/14 at 10:50 A.M. with administrative nursing staff D revealed the infection control logs were not completed thoroughly. Staff D reported he/she did use a map to document infections in the building to reduce the spread of infections but did not complete the forms to show if the infection was facility acquired, dates of antibiotic completion, or the date the infection was resolved. He/she also stated the facility held inservices for all staff regarding infection control topics such as blood borne pathogens, hand washing, and isolation precautions.

The undated policy provided by the facility regarding the infection prevention program revealed the 5 goals of the program were surveillance, outbreak investigation, policy and procedure review, staff education, and quality assurance and process improvement.

The facility failed to develop and maintain an infection control program for surveillance of infections for residents residing in the facility.